Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF DALLAS
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

TWIN CITY FIRE INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-3573-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health of Dallas to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine to be 'fair and reasonable' amount for this outpatient surgery." "Per the applicable Texas fee schedule the correct allowable would be per the DRG 463. The allowable for this DRG per Medicare is $33,439.91, we have also attached the print out for your review from the Medicare pricer program. The correct allowable would be at 143% making the allowable at $47,819.04. Based on your payment of $36,199.55, there is an additional of $11,619.52, still due at this time." "**We submitted a reconsideration to get a resolution prior to filing this dispute but the carrier is staying with their original allowance**."

Amount in Dispute: $11,619.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requesting invoice for Implants for further allowance."

Response Submitted by: Specialty Risk Services, 1851 East 1st Street, Suite 200, Santa Ana, CA 97205

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2010 through September 3, 2010	Inpatient Hospital Surgical Services	$11,619.52	$11,619.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 8, 2010
   - W1 –WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. REPRICING INCLUDED IN THE DRG RATE.

   - Explanation of benefits dated May 31, 2011
   - 16 –Claim/service lacks information which is needed for adjudication.
   - 18 –Duplicate claim/service.
   - W1 –Workers Compensation State Fee Schedule Adjustment.
   - W3 –Additional payment made on appeal/reconsideration.
   - Note: Further information required. A copy of an invoice showing the cost of the item or device must be received. The invoice must include the name of the manufacturer and type of device or model.

   Explanation of benefits dated August 10, 2011
   - 18 –Duplicate claim/service. Request for reconsideration reviewed. No further payment recommended.

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Did the respondent support denial reason code '16'?
5. Did the respondent support denial reason code '18'?
6. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. No documentation was found to support a contractual agreement between the parties to this dispute. Therefore, the Division concludes that the disputed services are not included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).
4. The respondent denied reimbursement based upon "Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. A copy of an invoice showing the cost of the item or device must be received. The invoice must include the name of the manufacturer and type of device or model. The Division finds that the denial reason clearly states the additional documentation needed for adjudication. However, the requestor did not request separate reimbursement for the implantables. For this reason, the Division finds that the respondent's 16 claim adjustment code is not supported.
5. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
6. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows:

   The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 463 is $33,492.25.

   This amount multiplied by 143% is $47,893.92.

   The total maximum allowable reimbursement (MAR) is $47,893.72.

   This amount less the amount previously paid by the respondent of $36,199.55 leaves an amount due to the requestor of $11,694.37.

   The requestor's *Table of Disputed Services* lists the total amount in dispute as $11,619.52.

   The Division concludes that the requestor is entitled to $11,619.52 additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $11,619.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $11,619.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 16, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.